CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING		COMPL	ETED
			B. WIN	LDING		03/17/2	011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1			
COVENIT	RY MEADOWS AS	SISTED LIVING			/ JEFFERSON BLVD		
COVENT	RT WEADOWS AS	SISTED LIVING		FORT	VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
R0000	This visit was fo	r the Investigation of	R00	000	March 30, 2011 Ms. Kim		
10000	Complaint IN00	•	100	,00	RhoadesIndiana State		
	Complaint invo	080771.			Department of Health2 North		
					Meridian St.Indianapolis, IN		
	•	086771 - Substantiated.			46204 Dear Ms. Rhoades,		
	State residential	deficiencies related to the			Please accept this Plan of		
	allegations are c	ited at R035, R241 and			Correction for Complaint Surv	ey	
	R243.				(IN00086771) as our letter of Credible Allegation. The prov	ider	
					respectfully requests a desk	1401	
	Survey dates: M	Iarch 16, 17, 2011			review in lieu of a post survey		
					revisit on or after April 2, 2011		
	Facility number:	005846			Please feel free to call me with	ı	
	Provider number				any questions. Sincerely,		
					Nathan A. Jackson, HFAGene	ral	
	AIM number: N	I/A			ManagerCoventry Meadows		
					Assisted Living		
	Survey team:						
	Sheryl Roth RN,	, TC					
	Christine Fodrea	RN					
	Census bed type						
	Residential: 73	•					
	Total: 73						
	Census payor typ	pe:					
	Other: 73						
	Total: 73						
	Sample: 9						
	*						
	These state resid	ential findings are cited					
		ith 410 IAC 16.2-5.					
	in accordance w	iui 710 IAC 10.2-3.					
	Onality review 3/18	3/11, by Suzanne Williams, RN					
	Quality To view 3/10						
			<u> </u>				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

S8Y211

Facility ID:

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPL	ETED
			B. WIN			03/17/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				V JEFFERSON BLVD		
COVENT	RY MEADOWS AS	SISTED LIVING			WAYNE, IN46804		
					1		(37.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	DATE
		· · · · · · · · · · · · · · · · · · ·	+			_	
R0035	Based on record	review and interview, the	R00	35	The creation and submission of		04/02/2011
	facility failed to	ensure 2 of 9 residents			this plan of correction does no constitute an admission by this		
	reviewed for immunization administration				provider of any conclusion set		
	(pneumococcal/f	lu) did not receive the			forth in the statement of		
		ter the resident had			deficiencies, or of any violation	n of	
		dent #C, Resident #J).			regulation. This provider		
	`	her failed to ensure			respectfully requests that the		
	_	ere signed and in the			2567 Plan of Correction be		
		· ·			considered the Letter of Credil Allegation and requests a desl		
	chart before adm	· ·			review in lieu of a post survey	`	
		or 2 of 9 residents			revisit on or after 4/2/11. R 0	35	
	`	ent #E and Resident #G)			Resident's Rights It is the		
	in a total sample	of 9 residents.			practice of this provider to com	nply	
					with all Resident's Rights for		
	Findings include	:			Residential Care. What		
	_				corrective action(s) will be		
	1. Resident #C's	record was reviewed on			accomplished for those		
	3/16/11 at 12:30	p.m. The record			residents found to have beer	י ו	
		nt #C's diagnoses			affected by the deficient practice? • The facility will		
		re not limited to, diabetes			ensure that only residents that	,	
	mellitus, high blo	·			consent to the immunization w		
	, ,	*			receive it and the consent form		
	hypothyroidism.				are signed and in the resident		
					clinical record before		
		eumococcal Vaccine			administering immunizations.		
		ndicated Resident #C had			How will you identify other	,	
	declined the imm	nunization since she had			residents having the potentia	ai	
	already received	the vaccine after age 65.			to be affected by the same deficient practice and what		
					corrective action will be take	n	
	A "pneumococca	l immunization" consent			Any resident who resides a		
	•	7/08, indicated the			Coventry Meadows Assisted	-	
	· ·	of attorney had granted			Living has the potential to be		
	•				affected by the alleged practic	e. ·	
	permission at tha				The Clinical Director will		
		f the pneumococcal			in-service all licensed nursing	_	
	immunization. T	here was not			staff on or before 4/2/11 on the		
					new immunization policy. Wh	ıat	

I			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
			B. WING		03/17/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET	TADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	KOVIDER OR SUPPLIER		7833 \	W JEFFERSON BLVD	
	RY MEADOWS AS			WAYNE, IN46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	•	DATE
		the clinical record to		measures will be put into pla	
	indicate the imm	unization was		or what systemic changes y will make to ensure that the	ou
	administered at tl	hat time.		deficient practice does not	
				recur? • A new immunization	n l
	The "Mantoux D	ocumentation Form"		policy will be followed that	"
		eumonia vaccine was		includes the following steps:	
	•	by LPN #1. No consent		Licensed nursing staff will obt	ain
	_			a consent or declination for th	e
		n the clinical record for		pneumococcal/flu vaccination	l l
		n of the immunization on		Clinical Director or designee	vill
	2/9/11.			review all consents or	
				declinations.	
	The "Nurses Not	es," dated 2/9/11 at 1:00		If consent has been signed to receive an immunization, licer	
	p.m., indicated R	esident #C was given the		nursing staff will contact the	iscu
	pneumonia shot i	in her left arm.		physician for an order.	
	•			Once the consent and physic	an
	The medication a	administration record for		order have been obtained,	
		tions," dated 2/1/2011		documentation of the	
				administration of the vaccine	will
	_	1 for Resident #C,		be documented on the MAR.	
		dent's temperature was to		72-hour follow-up will be done and documentation of any	;
		e days on second shift		symptoms or side effects will	be
	due to the resider	nt receiving a pneumonia		noted in the resident nurse ca	
	shot. There was	no documentation on the		section of the clinical record.	
	"Routine Medica	tions" form to indicate		If a resident refused vaccine,	
		tion was administered,		indicate the reason for refusa	l on
		as given, nor was there		the immunization record.	
		nurse administering the		How the corrective action(s)	l l
		nuise auministering the		will be monitored to ensure	
	immunization.			deficient practice will not re	cur,
	0 2/1//11 4 2 6	Of the District C		i.e., what quality assurance program will be put into place	_
		00 p.m., the Director of		The Clinical Director or	, <del>c</del>
		s indicated she was		designee will complete an	
		consent or physician		Immunization CQI tool weekly	/ x4,
	order in the clinic	cal record for the		monthly x3, then annually as	
	pneumococcal in	nmunization for Resident		needed. A copy of all comp	
	-			consent forms will be kept in t	he

I			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		03/17/20		
			B. WIN			03/17/20	J11	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
COVENT	RY MEADOWS AS	SISTED LIVING		1	/ JEFFERSON BLVD WAYNE, IN46804			
(X4) ID	SUMMARVS	TATEMENT OF DEFICIENCIES	_	ID	, 		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE	
	#C.  2. Resident #J's: 3/16/11 at 12:45 diagnoses include to, dementia and The "History and Statement Form" indicated Resider annual flu shot.  The "Resident In History Form" in received the flu is 10/15/2010 by a agency.  No consent form clinical record for administration of 10/15/2010, nor order.  3. Resident #E's 3/16/11 at 1:15 p diagnoses include to, diabetes and of A telephone order.	record was reviewed p.m. Resident #J's ed, but were not limited high blood pressure.  I Physical/Physician dated 11/30/09, and #J had declined an an annunization and Health dicated Resident #J had annunization on local home health  was located in the resident #J for the flu vaccine on was there a physician's arecord was reviewed and Resident #E's ed, but were not limited dementia.  It, dated 9/3/10, indicated okay to receive the			Clinical Directors office with the original kept in the resident clinical record · Data will be submitted to the General Manager. · The Clinical Direct is responsible for the program compliance. · Noncompliance with facility policy may result in disciplinary action up to and including termination.  Compliance date: 4/2/11	tor		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUIL			03/17/2	
			B. WING		A DDDEGG CITY GTATE ZID CODE	00/11/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  JEFFERSON BLVD		
COVENT	RY MEADOWS AS	SISTED LIVING			VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		nmunization and Health	-	TAG	DIA TELENCT )		DATE
	History Form" indicated Resident #E had received the flu immunization on						
		local home health					
	agency.	local nome nearm					
	agency.						
	No consent form	was located in the					
		or Resident #E for the					
		f the flu vaccine on					
	10/15/2010.						
	4. Resident #G's	record was reviewed					
	3/16/2011 at 1:20	p.m. Resident #G's					
	diagnoses includ	ed, but were not limited					
	to, dementia and	anxiety.					
	The "Influenza V	accine Consent," dated					
	1	ated Resident #G had					
	declined the annu	ual flu shot.					
		nmunization and Health					
	1	idicated Resident #G had					
		munization injection on					
	1	local home health					
	agency.						
	No consent forms	was located in the					
		was located in the or Resident #G for the					
		or Resident #G for the  f the flu vaccine on					
	located.	vas a physician's order					
	iocaicu.						
	On 3/17/2011 at	9:00 a.m., the Director					
	011 3/1 // 2011 at	7.00 a.m., the Director					

l	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED  03/17/2011	
			B. WI			00/11/2	-011	
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE			
COVENT	RY MEADOWS AS	SISTED LIVING		1	JEFFERSON BLVD VAYNE, IN46804			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	_	ces indicated the home						
		ually obtains their own						
		was unable to get a copy						
		or locate one in the						
		She further indicated, if						
	the facility admir							
		he facility would then						
		nt before administering						
	any vaccine.							
	This state residential	I finding relates to complaint						
	IN00086771.							
							<u> </u>	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) N			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
			B. WIN			03/17/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				W JEFFERSON BLVD		
COVENT	RY MEADOWS AS	SISTED LIVING			WAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
R0241			R02	41	R 241 Health Services It is the		04/02/2011
	Based on record	review and interview, the			practice of this provider to ens		
	facility failed to	ensure pneumococcal			the administration of medication		
	_	u vaccines were not			and the provision of residentia nursing care shall be as order		
		hout a physician order for			by the resident's physician.	<del>J</del> u	
					What corrective action(s) wil	ı	
		reviewed for medication			be accomplished for those	-	
		a total sample of 9.			residents found to have beer	1	
	(Resident #C, #F	, #G, #H, #I, and #J)			affected by the deficient		
					<b>practice</b> · Licensed nursing		
	Findings include	:			staff will obtain physicians order	ers	
	C				for all residents with a signed		
	1 Resident #C's	record was reviewed on			consent for all immunizations.		
					How will you identify other		
	3/16/11 at 12:30	_			residents having the potentia	al	
		nt #C's diagnoses			to be affected by the same		
	included, but we	re not limited to, diabetes			deficient practice and what		
	mellitus, high blo	ood pressure and			corrective action will be take		
	hypothyroidism.				· Any resident who resides at		
	31 3				Coventry Meadows Assisted Living has the potential to be		
	An undated "Pne	rumococcal Vaccine			affected by the alleged practic	Δ.	
		idicated Resident #C had			The Clinical Director will	<b>.</b>	
					in-service all licensed nursing		
		nunization since she had			staff before 4/2/11 on the new		
	already received	the vaccine after age 65.			immunization policy. What		
	A consent form,	dated 11/17/08, indicated			measures will be put into pla	ce	
	the resident's pov	wer of attorney had			or what systemic changes yo	ou	
	granted permission	on at that time for the			will make to ensure that the		
		f the pneumococcal			deficient practice does not		
		No consent was noted in			recur · A new Immunization		
					policy will be followed that		
		d for the administration			includes the following steps:	nin.	
	of the immunizat	tion on 2/9/11.			Licensed nursing staff will obta a consent or declination for the		
					pneumococcal/flu vaccination.		
	The "Mantoux D	ocumentation Form"			Clinical Director or designee w		
	indicated the pne	eumonia vaccine was			review all consents or	••••	
	given on 2/9/11 b				declinations.		
	51 VOII OII 2/ 7/11 (	<i>γ</i> Ε11 <b>1</b> π1.			If consent has been signed to		
					1		

005846

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC		COMPLETED	
			A. BUII B. WIN			03/17/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2		1			
00\/ENT		OLOTED LIVING		1	/ JEFFERSON BLVD		
COVENT	RY MEADOWS AS	SISTED LIVING		FORT	WAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	The "Nurses Notes," dated 2/9/11 at 1:00 p.m., indicated Resident #C was given the pneumonia shot in her left arm.				receive an immunization, licer nursing staff will contact the physician for an order. Once the consent and physic		
	pneumonia shot	in her left arm.			order have been obtained,		
					documentation of the		
	On 3/16/11 at 2:	00 p.m., the Director of			administration of the vaccine	will	
		s indicated she was			be documented on the MAR.		
	•	consent or physician			72-hour follow-up will be done and documentation of any	•	
		cal record for the			symptoms or side effects sho	uld	
					be noted in the resident nurse		
	•	mmunization for Resident			care section of the clinical rec	cord.	
	#C.				If a resident refused vaccine,		
					indicate the reason for refusa	l on	
					the immunization record.		
	2. Resident #J's	record was reviewed			How the corrective action(s)		
	3/16/11 at 12:45	p.m. Resident #J's			will be monitored to ensure	· ·	
		led but were not limited to			deficient practice will not re	cur,	
	_				i.e., what quality assurance		
	dementia and m	gh blood pressure.			program will be put into place	ce.	
					The Clinical Director or designee will complete an		
		d Physical/Physician			Immunization CQI tool weekly	, 44	
	Statement Form'	' dated 11/30/09,			monthly x3, then annually as	, AT,	
	indicated Reside	ent #J had declined an			needed. · A copy of all comp	leted	
	annual flu shot.				consent forms will be kept in	l l	
					Clinical Directors office with the	ne	
	The "Recident In	nmunization and Health			original kept in the resident		
					clinical record · Data will be		
	•	ndicated Resident #J had			submitted to the General		
		immunization on			Manager. • The Clinical Direction reasons in the program		
	10/15/2010 by a	local home health			is responsible for the program compliance. Noncompliance		
	agency.				with facility policy may result i		
					disciplinary action up to and	"'	
	No consent form	was located in the			including termination		
		or Resident #J for the			Compliance date 4/2/11		
		f the flu vaccine on			-		
	10/15/2010, nor	was there a physician's					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	r 1	(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			03/17/2011	
			B. WING			2011	
NAME OF F	PROVIDER OR SUPPLIER	8		T ADDRESS, CITY, STATE, ZIP CODI	<u> </u>		
COVENT	RY MEADOWS AS	SISTED LIVING		W JEFFERSON BLVD T WAYNE, IN46804			
						1	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION	
TAG	` ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE	
1110	order.	ESC IDENTIFICATION ORGANIZATION	1110			DATE	
	order.						
	2 Dogidant #I's	record was reviewed					
		p.m. Resident #I's					
		ed, but were not limited					
	_	pression, and high blood					
		diession, and high blood					
	pressure.						
	The "Droumese	ccal Vaccine Consent"					
		09, indicated Resident #I					
		e the pneumococcal					
		_					
		g to the recommended					
	schedule.						
	The medication i	record for February 2011,					
		nt #I had received a					
	pneumococcal in	months past the date of					
	the consent form	•					
	the consent form						
	No physician ora	der was located in the					
		or the administration of					
	Resident #I.	al immunization for					
	Resident #1.						
	1 Resident #U's	s record was reviewed					
	-	o.m. Resident #H's					
	_	ed, but were not limited					
	to, dementia, dep	pression, and anemia.					

005846

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAIN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUII			03/17/2	
			B. WIN		DDDEGG CITY GTATE ZID CODE	00/11/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE  JEFFERSON BLVD		
COVENT	RY MEADOWS AS	SISTED LIVING		1	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG				IAG	DIA TELENCT )		DATE
	The "Pneumococcal Vaccine Consent" form, dated 10/5/09, indicated Resident #H wished to receive a pneumococcal						
	vaccine.	cive a pheumococcai					
	vaccinc.						
	The medication r	ecord, dated February					
		Resident #H had received					
	, and the second	immunization on					
	2/14/2011.						
	No physician's or	rder for the					
	administration of	f the pneumococcal					
	vaccine was loca	ted in the clinical record					
	for Resident #H.						
		record was reviewed on					
	_	.m. Resident #G's					
	_	ed, but were not limited					
	to, dementia and	anxiety.					
	A !!I.u.fla.u.=a V.a	and Camandll farms					
		accine Consent" form, dicated Resident #G had					
	declined the flu v						
	decimed the Hu \	vacciiit.					
	The "Resident In	nmunization and Health					
		idicated Resident #G					
	received a flu im						
		local home health					
	agency.						
	<i>3</i> - <i>j</i> -						
	No physician's or	rder for the					
		f the flu vaccine was					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
THINDTEIN	or condition	DENTIL CATION NONDER.	A. BUILDING		03/17/2	
NAME OF F	AD OUTDED ON GUIDNI WED		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER		<b>I</b>	/ JEFFERSON BLVD		
	RY MEADOWS AS		FORT	WAYNE, IN46804		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DATE
	located in the clim#G.	nical record for Resident				
	3/16/11 at 1:25 p diagnoses includ to, dementia and The "Resident In History Form," d Resident #F recevacine by a local The medication reindicated Resident pneumococcal in 2/14/2011 by LP No physician's or administration of located in the clim#F.	N #1.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPL	ETED
			A. BUII			03/17/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹					
COVENT		CICTED LIVING			/ JEFFERSON BLVD		
COVENT	RY MEADOWS AS	SISTED LIVING		FORT V	WAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
R0243			R02	43	R 243 Health Services		04/02/2011
	Based on record review and interview, the				It is the practice of this provider t		
		ensure the medication			ensure clinical records are comple	ete,	
	•	all of the details of a			including documentation of		
					administration of medication and		
	•	njection such as the time,			treatment records.		
		tion, dosage, and the			What corrective action(s) will be		
	_	rson administering the			accomplished for those residents		
	drug for 1 of 9 re	esidents reviewed for			found to have been affected by t		
	medication admi	nistration in a total			deficient practice?		
	sample of 9. (Re	esident #C)			-		
	•	,			All physician's order for		
	Findings include	.•			pneumococcal/flu vaccine will be		
	1 manigs include	·•			transcribed correctly on the		
	1 D //C/!»				Medication Administration Recor		
		s record was reviewed on			and in the clinical record by licen	ised	
		p.m. The record			nursing staff.		
	indicated Reside	nt #C's diagnoses			How will you identify other	.	
	included, but we	re not limited to, diabetes			residents having the potential to affected by the same deficient	o be	
	mellitus, high blo	ood pressure and			practice and what corrective		
	hypothyroidism.	_			action will be taken.		
	, p,				action will be taken.		
	The "Montour D	Occumentation Form"			· Any resident who resides	at	
					Coventry Meadows Assisted Livi		
	•	eumonia vaccine was			has the potential to be affected by	the !	
	given on 2/9/11 1	by LPN #1.			alleged practice.		
					· The Clinical Director will		
		tes," dated 2/9/11 at 1:00			in-service all licensed nursing sta	.ff	
	p.m., indicated R	Resident #C was given the			before 4/2/11 on the new		
	pneumonia shot	in her left arm.			immunization policy.		
					What magazine		
	The medication a	administration record for			What measures will be put into place or what systemic changes		
		ation," dated 2/1/2011			you will make to ensure that the	.	
		11 for Resident #C,			deficient practice does not recur		
	_				· A new Immunization police		
		ident's temperature was to			will be followed that includes the		
	be taken for three	e days on second shift			following steps:		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		NSTRUCTION (X3) DA		DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIM DDIG			COMPL	ETED	
			A. BUILDING			<del></del> 03/17/2011		
			B. WING					
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP CODE			
				7833 W JEFFERSON BLVD				
COVENT	RY MEADOWS AS	SISTED LIVING	FORT WAYNE, IN46804					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		P	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T		HOULD BE COM		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE		
	due to the resident receiving a pneumonia				Licensed nursing staff will obtain	ıa		
	shot. There was no documentation on the				consent or declination for the			
	medication record to indicate the vaccine			pneumococcal/flu vaccination.				
					Clinical Director or designee will			
	was administered, when, where, dose, or				review all consents or declinations.			
	initials of nurse a	administering it.			If consent has been signed to receive			
					an immunization, licensed nursing			
	On 3/16/11 at 2:00 p.m., the Director of				staff will contact the physician fo			
	Nursing Services indicated she was				order.			
	unable to find administration details in			Once the consent and physician order				
	the clinical record for the pneumococcal			have been obtained, documentation of the administration of the vaccine				
	immunization for Resident #C.			will be documented on the MAR.				
		i κesident πe.			72-hour follow-up will be done as			
	On 2/17/11 at 11:00 a re- 1 DNI #2				documentation of any symptoms			
	On 3/17/11 at 11:00 a.m., LPN #2				side effects should be noted in the			
	indicated all medications and injections a			resident nurse care section of the				
	resident is to receive should be listed on			clinical record.				
	the medication record. She further			If a resident refused vaccine, indicate				
	indicated when a medication is given or			the reason for refusal on the				
	an injection administered, the details			immunization record.				
	should be documented on the medication				How the corrective action(s) will			
					be monitored to ensure the			
	record.			deficient practice will n		,		
	This state residential finding relates to complaint IN00086771.				i.e., what quality assurance			
					program will be put into place.			
	11100000771.				· The Clinical Director or			
					designee will complete an			
					Immunization CQI tool weekly x			
					monthly x3, then annually as need	aea.		
				· A copy of all completed consent forms will be kept in the				
					Clinical Directors office with the			
					original kept in the resident clinic			
					record	·u1		
					Data will be submitted to	the		
					General Manager.	,110		
					· The Clinical Director is			
					responsible for the program			
					compliance.			
					r - r			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/17/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  7833 W JEFFERSON BLVD  FORT WAYNE, IN46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)				
				Noncompliance with facility p may result in disciplinary action to and including termination				
				Compliance date: 4/2/11				